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ABSTRACT

Described are the activities of a federally-funded mental health and mental retardation center located in the Appalachian region of Kentucky. The typical treatment approach is explained; and the stereotyping of clients, lack of responsiveness to groups of clients, and neglect of mental health education in general are pointed out. The findings are presented statistically and generalized to other clinics and agencies in Appalachia. Discussed are such suggestions for improvement as the stressing of accountability and the use of empirical methods of needs assessment. (Author/IM)

Accountability for Appalachia's Mental Health Programs: A Case Study

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The activities of a federally-funded mental health-mental retardation center located in the Appalachian region of Kentucky are statistically described. The lack of responsiveness to different groups of clients and the neglect of mental health education in general are dealt with. Many mental health workers in the Appalachian area have stereotyped their clients and the typical treatment approach is presented. These findings are generalized to other clinics and agencies in this region of Kentucky, and suggestions for improvement are discussed.

Accountability for Appalachia's Mental Health Programs: A Case Study

Rogers and Richmond (1975) pointed out an absurd condition which has befallen psychologists in Appalachia. Psychologists have been asked by Appalachia's financial aid agencies to determine their clinetele's needs by administering intelligence tests. Obviously, the process of equating the financial needs of Appalachia's poor and WAIS performance is quite meaningless. Unfortunately, such testing seems to be relished by mental health administrators because it is quick, clean, and lucrative. This ridiculous procedure perpetrated by Appalachia's financial aid agencies and mental health clinics is but one of many abuses directed against the essentailly powerless and defenseless Appalachian poor.

Many concerned individuals have been crying for accountability in the field of mental health for many years, but probably no where is such accountability needed more than in core Appalachia. There definitely is a lack of data dealing with mental health services in Appalachia, and the potential data seems to be closely guarded by each respective program. This is an isolated case study, but based upon observations in a number of such Appalachian programs, the writer is quite aware that the data can easily be generalized to other Appalachian mental health programs.

All of the comprehensive care programs in this section of the country are of a regional nature, involving varying numbers of counties. Therefore, in all cases there is a centralized office with numerous satellite offices in the surrounding counties. A

critical observation reveals that although mental health facilities and services are available in each county, generally the bulk of the staff and services is housed in the centralized office. Satellite offices often seem to be manned minimally or only by "token representatives." Psychotherapy, psychiatric treatment, and psychological testing are usually provided by traveling professionals who visit each office.

It is a fact that many of these programs would find existence difficult if federal funding were eliminated. The majority of the patients served come from the group designated as the "Appalachian poor" who usually pay nothing or only a token amount for services. This situation has been remedied somewhat, in that, these mental health centers can now collect monies from many third party sources such as Medical Assisitance, Social Security, Child Welfare, etc. These federally funded programs are obligated, though, to serve everyone "in need" in their respective regions. Thus, all programs have a "sliding-fee scale" which translates what a patient should pay for treatment based upon his family size and income.

The data presented is based upon the patient population of a representative Appalachian, centralized mental health office. Theoretically, the data obtained at a central office would represent the "best efforts" of a program because of the high concentration of professionals. The results presented were derived from the entire active mental health caseload of this centralized office.

The entire five-country region commanded from this central office reports a population of about 60,000 persons with approximately 67 percent of the region's families at or below the poverty level.

The mean regional family income has been calculated at about $3,700. Additionally, governmental officials in this area reported the unemployment rate to be 35 to 45 percent, with approximately 70 percent of the region's adults, 25 years of age or older, possessing eight years or less of formal education.' Any mental health grant request for federal funds to operate presenting these types of statistics obviously would stand a very good chance for approval.

However, a closer look needs to be undertaken. As previously pointed out, these programs are expected to serve everyone in their respective regions. These mental health operations are encouraged to attract community support and paying clientele who can help finance the programs in order that excessive dependence on federal financing might be reduced. The county served by this centralized office reports rather different statistics from those applicable to the region (County and City Data Book, 1972, 1973). This particular county boasts a population of about 18,000 persons with approximately 25 percent of the county's families classified as being at or below poverty level. Also, this county reported an unemployment rate of only 4.8 percent, with a median family income of $5,635. This particualr county also is industrialized, urbanized, and is the home of a large, multi-purpose college. Therefore, the data presented are the results of one mental health center's activities with a rather sophisticated "Appalachian population," representing about one third of the population of the program's catchment area.

Clients Treated

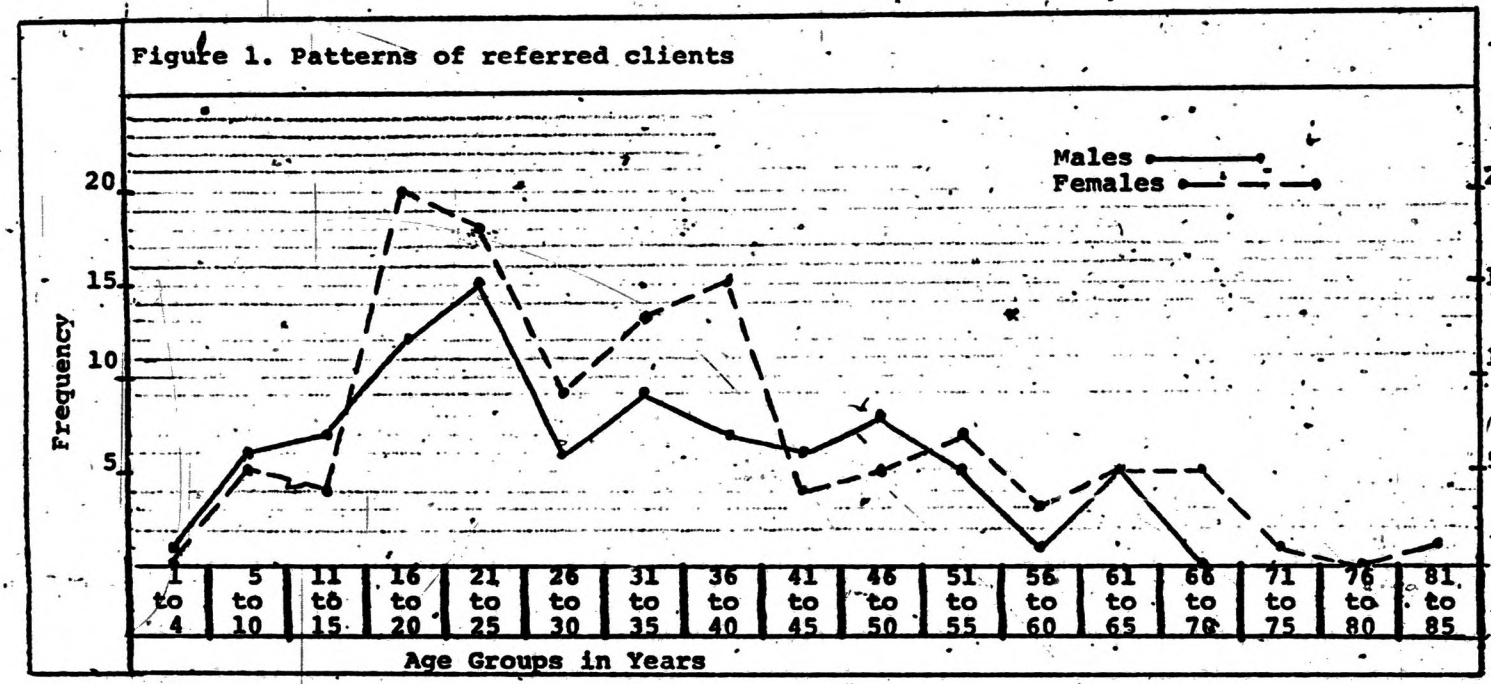
Recently, the entire active mental health caseload served by this central office which numbered 203 clients (88 males and 115

females) was examined. Thirty-two were classified as pre-schoolers or elementary and secondary students, and 35 others were enrolled at the local college, but they were not local inhabitants. This group of clients was served by a clinical staff numbering about 15 persons including medical doctors, psychologists, social workers, and mental health workers (Bachelor-level paraprofessionals). The mean age of the patients served was 32.5 years, and the total group represented new, long-term, and short-term patients. Figure 1 details the patterns of referral by age and sex.

Insert Figure 1

Although fewer males were referred, the overall patterns for the two groups are generally similar. There is a marked lack of service to children, adolescents, and the elderly for both sexes. However, when one closely looks at the caseload volume, there seems to be a lack of service to the overall community, in that, only about one percent of the county's population was being served. One might conjecture that this Appalachian county's population could be quite well-adjusted, but it is a well-known, but undocumented, fact that many individuals from all socio-economic levels in core Appalachia seek psychological or psychiatric counseling and treatment in distant major cities. Many Appalachians travel to such cities as Lexington, Kentucky, Cincinnati, Ohio or even Knoxville, Tennessee for the same type of treatment that they might procure locally. Possible reasons for this phenomenon include (1) a lack of education concerning mental health and mental illenss, (2) embarrassment because treatment is needed, (3) acquaintances work at the local mental health center

Figure 1. Patterns of referred clients



and a concern over confidentiality arises, and (4) a lack of trust in the competency of the local professionals. These reasons were related to the writer by both professional and non-professional sources in several Appalachian communities over an extended period of time.

The administrators claimed that the typical client seen by its professionals was "very poor with about an eighth grade education." A review of the center's records on indigenous clients indicated that this claim was supported. However, based upon data from the County and City Data Book, 1972 (1973), one would expect the typical client seen by this central office to be middle class with about an eleventh or twelfth grade education.

As previously noted the information presented here was collected on the entire patient caseload during a typical month of operation. The caseload numbered 203 patients (88 males and 115 females), indicating that roughly one percent of the county's population was being served. A closer look at these client's progress charts by this writer revealed that actually 74 of the 203 clients, about 37 percent, had voluntarily terminated service, but they were still being carried as active clients. Thus, this center was actually dealing with 129 active clients. At that time, the center's officials were expressing their delight with the high volume of work this well-established mental health clinic was enjoying.

Table 1. Referral Sources	
Referral Sources	Number of Patients Referred
Physicians	119
Self-Referral	21
Police or Court Related	14
State Agencies	13
Another Patient	10
University	9
School Systems	6
Relatives	6
Friends	5
	Total = 203

Who Referred Clients?

The following table summarizes the sources of referral of clients to the mental health center. As can be easily noted, the

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Insert Table 1

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most common sources of referral (59 percent) were private physicians. Other than physicians, it is noteworthy that there seems to be a great lack of support from governmental agencies, particularly the local school systems. Overall, this particular mental health center spent literally no effort in attempting to educate and introduce programs to the public, and the data certainly reflects the neglect.

What Services Were Rendered?

The great frequency of physician-originated referrals unfortunately reinforced the concept of the "medical model" for many of these Appalachians, who willingly went to the "nerve doctors" for "nerve medicine.". This whole procedure has probably led to an excessive use of chemotherapy with psychiatric clients treated by Appalachian mental health centers. The general rule of thumb among the "helping professionals" in core Appalachia seems to be that the local inhabitants are "non-verbal and uninterested in talking about their problems." The use of medicine often seems to be a viable alternative. This particular mental health center apparently supported the idea that medication is a useful alternative with Appalachians, because about 62 percent of the treated clients were adminstered medicines. Table 2 outlines the types of services performed by this clinic.

Insert Table 2

Conclusions

Much of this data speaks for itself, in that, the examined mental health program was and may still be quite deficient in their expected dutles. However, this writer believes that this particular program may not be the worst program in the Appalachian mountains. Based upon personal experiences, the writer knows that deficiencies and ineptness in numerous agencies and organizations are widespread in this part of the country. This particular centralized office, which had been described often as a model operation, was not really meeting the needs of a rather sophisticated, diverse, Appalachain population. We should assume then that the work carried on in the satellite offices, which are generally only token efforts, was certainly of dubious quality. Unfortunately, two thirds of this region's population was enduring and continues to endure these sub-par, satellite office efforts.

What is needed?——Accountability! Many experts in the field of mental health work have called for accountability by mental health programs. The data presented here surely supports this idea. Many programs in Appalachia seem to exist and expand for their own benefit, rather than for the benefit of the communities they serve. This growth and expansion also often seems to be tempered to meet federal guidlines rather than "real" community needs. The data pre[illegible] here and easily observable on the scene

Table 2. Types of services performed	
Service	Number of Patients
Psychotherapy Only	49
Chemotherapy With Verbal Therapy or Conversation Concerning Medicinal Effects	80
Patients Terminated Service Voluntarily Against Advice of Mental Health Staff	74
	Total = 203

in many Appalachian communities points to the lack of effort by many mental health centers to respond to and educate their respective populations. Many federally-supported agencies seem to reject empirical methods to determine the community's attitudes and perceptions of their programs. When the Appalachian mental health programs do not reflect appropriate results to funding sources, program directors can always point out how "uneducated and poor" their clientele are. The poor too often have been used as "scapegoats" for incompetence. Enough talk has been generated concerning accountablity by mental health agencies, action is now the word! This action should obviously be taken with the examined mental health program, and this action must begin soon via three groups: the community and the state and federal governments. However, this paper presents a situation which probably exists in many areas of the country, i.e., Indian reservations, ghettoes, etc. It must be rectified, because deficiency, incompetency, and unresponsiveness on the part of societal agencies injures all levels of society, but especially the poor.

References

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